Voices from the Floor

Volume 2 | Issue 2 Article 1

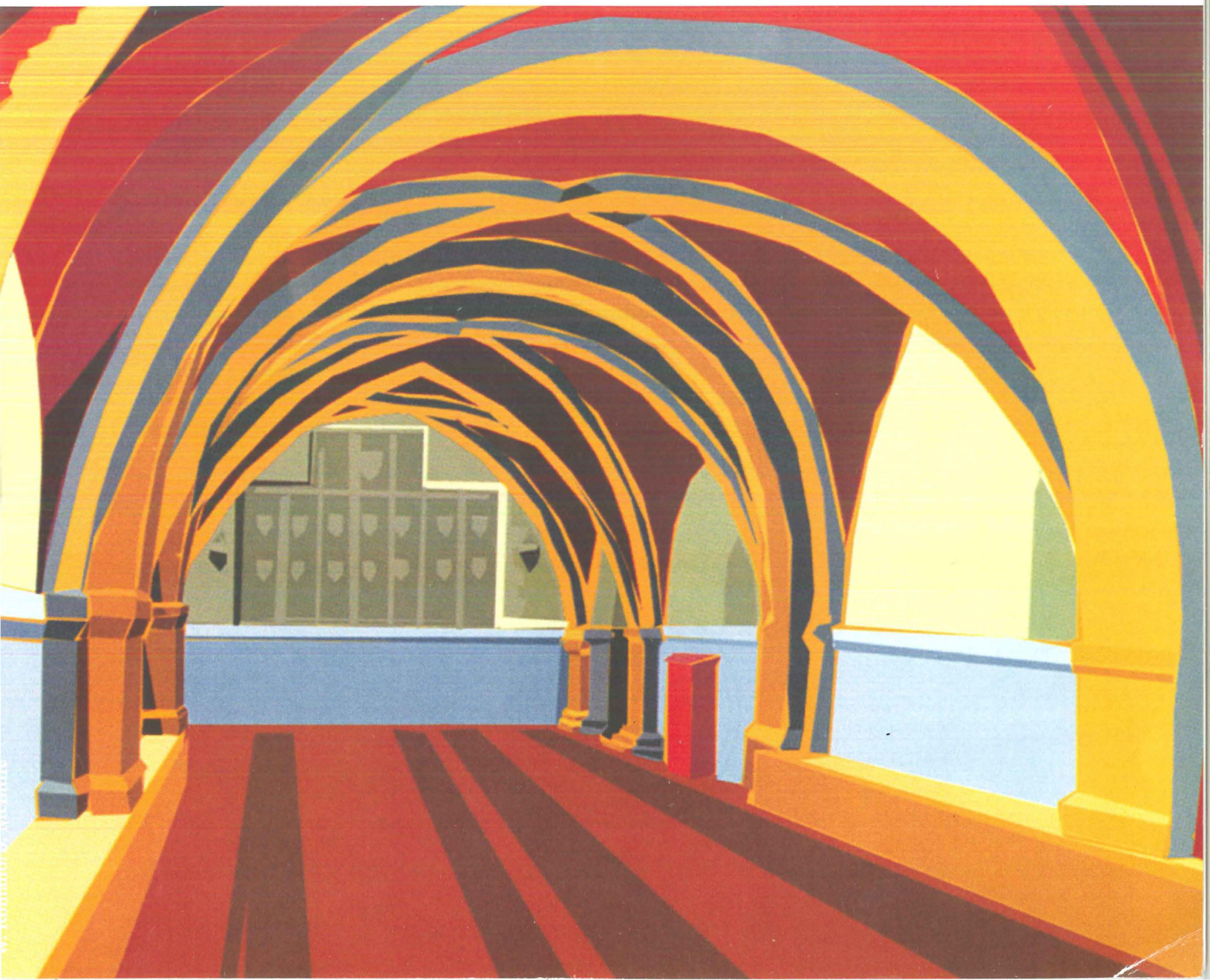
5-2010

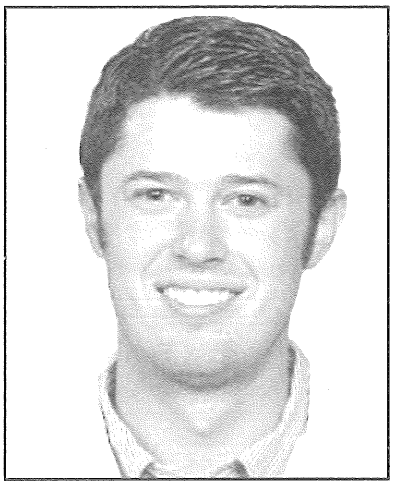
Voices from the Floor (May 2010)

PCOM

VOICES FROM THE FLOOR

JUSTIN GUTHIER, MS-III, *Chief Editor and Writer*
ROBERT CUZZOLINO EDD, *Administrative Consulting Editor*
CHARLOTTE GREENE, PHD, *Faculty Consulting Editor*





May 2010

Dear PCOM Community,

May is a busy and stressful month in the life of any PCOM medical student. If you are a 1st year student, you are taking the last exams of what was surely a difficult and intense year. 2nd year students are studying for what will be one of the most important exams in their career. 3rd year students are beginning the 'audition rotation' time period of their medical education and 4th year students are wrapping up that last rotation and preparing for internship.

In order to be successful, medical students plan months, even years ahead to achieve a final goal. By the end of 4th year, every medical student hopes that the hard work, sacrifice and long hours spent studying and on rotation has culminated in an acceptance into the residency program of their choice. As 3rd and 4th year students, we have some idea of what that experience will be like. We have interacted with interns and residents on rotation, emulated their confidence and swagger and in some cases envisioned ourselves in their shoes.

In this edition of *Voices from the Floor,* I have touched upon each period of the graduate medical education experience and beyond. As a student myself, I found it incredibly enlightening to gain the perspective of the intern, medical resident and GME director of a residency program. I would personally like to thank all of the attending physicians and medical residents at Roxborough Memorial Hospital for their guidance and teaching. Your lessons will undoubtedly benefit me in future rotations and my professional career. I hope everyone enjoys a look into the life of an intern, senior medical resident, GME Director and life beyond medicine.

Very Truly Yours,

Justin Guthier, OMS-III

I would like to thank

Christine Donovan,

Academic Coordinator,

Department of Neuroscience,

Physiology and Pharmacology

for proofreading this edition of

Voices from the Floor

Table of Contents

Roxborough Memorial Hospital

The Intern – Taking the First Steps – Jamie Zwanch, DO

Written by Justin Guthier, OMS-III

I first started thinking about becoming a surgeon when I was in grade school. It seems fairytale-ish, but it is the truth. For many years I worked towards my goal of becoming a physician and now I have begun my graduate medical training in Surgery in Dr Sesso's General Surgery Residency program. The path to where I am today was long and arduous but I have learned a great deal along the way.

Medical school attempts to expose you to all the different residencies and specialties in medicine, but as I look back on my third and fourth years of school, there is no one event that made me positive a career in surgery was for me. There was not a specific case or a certain night on call. I just looked at my own attitudes when I was on rotation for that specialty. Then based upon those, I chose the specialty I felt most comfortable with. I loved my nephrology rotation. I seriously considered doing an internal medicine residency and going for nephrology. Besides surgery, it was one of my favorite rotations. I did the rotation at Frankford Hospital with Dr. Levin and his group. Nephrology is a great rotation – one that I would consider high yield. You touch upon nearly every organ system and deal with the sickest of patients. You will definitely learn a lot. One piece of advice I have for students in their third and fourth year would be to branch out to programs outside of the Philadelphia area. Medicine is not the same everywhere. It is important to go out and see how it is practiced in different cities and different areas of the country.

As the months past and I got closer to making my decision, the more seriously I considered doing internal medicine. My decision was purely based on lifestyle. The residency training for internal medicine is quite different from that for surgery; the hours and the years are both longer to become a surgeon. I was married, and I did not know how conducive a surgical residency would be for a future father. Looking back at that period of my life, it was a really difficult time, but by far the factor that finally swayed my decision was simple – I enjoyed surgery the best and that is why I chose it for my career.

Internship is difficult. It is your first transition to true responsibilities for patients. You cannot be prepared for how busy you are going to be, you just have to experience it for yourself. There are bad and good call nights – there are great days when you feel like you are making a difference and other days where you feel like a cog in the wheel. Nothing prepares you for having your name on the order sheet. I have written orders as a student but it is not the same – there was always someone else looking over your shoulder. The first night on call – I thought really hard, "Does this patient really need a BMP in the morning?" very aware that my name was going to be on this order. I would like to think I was ready for it, but writing orders as the person in charge is a position and experience that no amount of reading and shadowing can prepare you for; it must be experienced firsthand. The most difficult part about being an intern is how frequently you lose track of time, and how many family activities you miss-it is just part of the territory. It is a case of putting in your time now so you can have a great life later on.

I recently became a father and started my internship – two incredibly monumental life experiences. Balancing a personal life and professional career can be trying at times, and I do not sleep as much as I should. To be honest, having kids really does change you, even after going through Pediatrics and OB/GYN I was not prepared. Every day, before I leave, and the first thing I do when I come home is to tell my son how much I love him. It is difficult, but I have a great, supportive wife and we are getting through this intern year together.

The tough cases, the recent cases are the patients that I remember most over the course of this intern year. There was one patient a couple months back – a 24 year old with mesenteric ischemia. I am going to remember him for a while because the surgical team was not sure of what was going on. His diagnosis hit us out of the blue. Until we got the CT back, we were thinking it was gallbladder. The CT scan instead showed thickening of the terminal ileum. We took care of him but it was a difficult diagnosis to make. This is one patient I will never forget.

Medical students also may have a few moments where they can stand out for good reasons and make a real difference for a patient without someone looking over their shoulder. The most vivid memory I have as a student was a case of acromegaly that I diagnosed. The residents were chasing blood sugars on this patient that we had just admitted. We walked into the room and it was textbook acromegaly. I turned to the residents and said, "This guy has acromegaly". They insisted he did not but I retorted, "Just look at him". Turned out in the end he did have it. As a third year medical student, I diagnosed this disease by just looking at the patient. It is one of those things that just makes you feel good and gives you confidence that you made the correct career choice.

As you begin to take on more patient care respon-

sibilities, you notice which patients are going to make your day and which ones are going to make you wish you did not get out of bed. Patients who do not care, patients who do not participate in their own well-being are the most difficult to deal with. You see it a thousand times; the same patients coming back into the hospital time and time again and no matter what you do, they will be back. You just get tired of seeing them. By far, the most rewarding patients are those with critical illnesses, I enjoy the challenge of saving a critical patient. In addition, the critical patients are monitored more closely, and you can get instant feedback on whether or not you made the right call. Patients and their families who appreciate what you are doing can also make you enjoy being a physician. It is nice to know that you are doing something for someone who feels touched by your actions. I have been in situations where patients and their families brought in chocolate and gifts. That really makes you feel special.

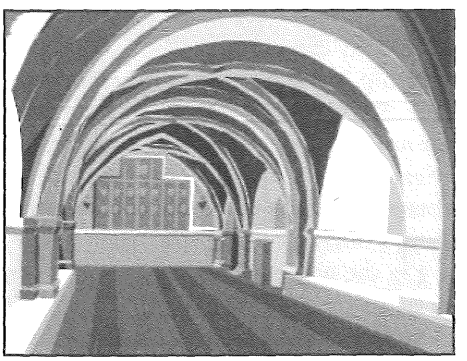
As an intern, it is your responsibility to teach the medical students and I try to do my best. I try not to put them on the spot. When I was a student I hated being put in that position so I try to avoid doing the same to them. My goal is to make the students feel relaxed and comfortable and to make the day interactive. I try not to force feed students facts, as it seems to make them less receptive...and interns do not always have the answer, as I am ready to admit when I do not know stuff. I remind them that's why there is always someone above you to help- a good third or fourth year medical student always makes the effort, and attempts to display basic knowledge. You need to know some pathology, microbiology and physiology. If you do get into higher level thinking, that is phenomenal. However, I am not looking for you to know everything. Just pick up on the basics and I will be happy, and so will your attendings. If you show that you are not interested, people will be less willing to work with you, and remember to always go into every rotation with an open mind.

After internship and residency, another thing I am looking forward to is that paycheck. When you get that first loan repayment bill – be ready. Four years of medical school adds up fast. When you see that number, the only thing you can do is laugh. Paying off your education is like paying the mortgage for a home that does not physically exist. What I am really looking forward to in the future is not having to cut corners financially with my wife anymore. That salary will provide a sense of security. It will be nice not having to worry about the little things. The other big reward for completing residency will be the responsibilities and freedom of being the attending physician. As a resident or intern, you may not always agree with the care plan. I am looking forward to being "The Guy."

If you are a student in your third and fourth year, it is never too early to be thinking about what you want to do with the rest of your life. Applying for residency is a complicated process. When you are applying, make sure that you know about the programs to which you are applying. You do not want to walk into a program on the day of your interview and not know anything about the program. It makes you look bad and makes you look unprepared. It is good to have some thoughtful questions on the day of the interview. The questions are indicative that you care about the program – not just anything that you can look up on the website. I know that it is not possible to get to rotate on every program that you are interested in, but for the ones that are your top choices, make sure that they at least know your face before the day of the interview. It makes them more comfortable with you. You in turn will know your way around the hospital and be more comfortable in the interview. In your interview, be honest. Going in and flat out lying to people is never a good idea. Be judicious about the information you provide and indicate your interest.

Obviously if you are interested in surgery or other very competitive residencies, you want to get yourself out there so the residents and most importantly the program director knows you. The upper level residents typically have a lot of input so make sure they know you. You want to come across as a hard worker, a person with whom they want to work. Despite your brilliance, if you come across as a jerk no one will want to work with you, and they are not going to let you into the program. Mistakes are going to happen, you are not going to know the answers to every question, but you should show some progression. You must show that you can learn from mistakes.

I know it is trite to say but – try not to get overwhelmed by the process. Do not always look too far ahead. Take some time for yourself, whether its 5 or 10 minutes a day or you will get burned out. If you want to become a surgeon, be sure you know the road is really long. But if you love surgery, no matter how long the road is you will know you made the right choice.



The Senior Resident – Beginning the Journey – Richard Donlick, DO

Written by Justin Guthier, OMS-III

My path to medical school was much different from many of my classmates. You could say that I followed in my father's footsteps. I did not even think about becoming a physician til much later in life – just like my father. When my Dad graduated in 1979, he was 36 years old with 4 kids. C. Everett Coop was the commencement speaker that year; he was a pretty important guy at the time. He would later become the Surgeon General of the United States. I was pretty inspired by my Dad's accomplishment but it would be many years later until I would follow in his footsteps.

Before medical school I was in the Air Force and worked in the Counterterrorism unit. It was pretty exciting work, but in the back of my mind, I always wanted to become a physician. With children of my own, I too decided to go for my dreams of becoming a physician. As a medical student, I experienced many life-changing events. Delivering a child, besides my own children, was one of the greatest moments of my education. I have never seen that much joy and complete contentment when the mother took her baby in her arms for the first time. I can see the scene in my mind clear as day. As a medical student the experience of delivering a baby was a lot different than becoming a father for the first time. When you are learning, you are more observant of your surroundings. It probably helped that as a medical student I was a lot more nervous. Looking back at my residency training it is difficult to grab one moment that sticks out in mind. Undoubtedly though, I have surprised myself with the abilities and knowledge I have gained over the past three years. I never thought I would have the skills necessary to identify and diagnose a disease process and in turn save a life on my own. Beyond any particular experience, that by far is the most influential feeling in my graduate and undergraduate education. To that end, I give all the credit and respect to the physicians who trained me.

I knew I wanted to practice internal medicine and PCOM's program made sense for me and my family. In PCOM's program, I get the responsibility to handle the most serious of cases in the critical care setting. There are not many other internal medicine programs that delegate and expect more of their residents than PCOM's. One patient in particular sticks in my mind. A 50-year-old priest was admitted to the hospital. He had recently returned from a trip to Panama where he had been doing missionary work in the jungles. To travel from village to village, he had been using a donkey as his primary mode of transportation. I am not a Catholic, but it does not matter – I was determined to treat and bring back to health another human being who had dedicated his life in service of others. As his condition in the hospital worsened, I convinced him to be intubated. He agreed and unfortunately he never woke back up. He died from complications of a severe pneumonia. We tried everything that we could to save him and in turn learned more from his case than I have from any other. I did a swan, did zypress, inverse ratio ventilation, bi-level ventilation and 5 pressors. Many priests who had gone on the same trip suffered from severe pneumonias as well. The CDC came in and did autopsies. His death stuck with me for a long time. Yet, in his death, I learned more from his case than from any other patient. I will use those lessons for the many thousands of patients yet to come.

In residency, you have a responsibility to teach those under you. I love to teach. Teaching makes my day worth it – teaching is what sometimes gets me through the day. For students who come to Roxborough for their second year H&P, I try to make their experience as realistic as possible. There are certain things that medical students should know as they progress through their third and fourth years. I do get frustrated sometimes with students and their base knowledge. If I ask a group of students what is the organism you find in otitis externa, I should not hear crickets. I should see hands up in the air. I am not an in-your-face type of guy and I am not expecting you to be an infectious disease genius. But I do expect that a simple fact like that, where it is gone over multiple times in multiple classes and emphasized on boards studying, that this fact should stick. When students are in their first and second years, I feel like they study for the test. Even the students who go to class, usually do it to study for the boards. They do not have that sense of urgency that the information they are given is not simply for test taking and grade achievement. This information will ultimately allow them to do their job as a physician and if given the chance, save a life.

When a medical student is on rotation, I would like to see them display maturity and a strong work ethic. For the most part they do. I have been incredibly impressed with the effort my students have put forth this month. You should know basic antibiotics. You should be able to answer with ease the frighteningly easy questions – swimmer's ear, patient sits in a hot tub, what's the bug? Easy stuff like that. I do not care if you can recite the citric acid cycle. It doesn't help you much in everyday medicine. It is important to know for the boards but in the big picture, you should not emphasize information like that. Memorizing the citric acid cycle is part of the game you play to get to where you want to be. When you are taking the boards, they are not simply measuring your knowledge base; they are testing your endurance. That part of the

boards is a test of your scholastic and personal fortitude.

The information in an organic or biochemistry class is not as important as the lessons you learn from persevering through the material and the challenge. When you get to topics like microbiology and physiology, those directly impact your ability to perform as a medical student on rotation and ultimately your ability to treat patients. In terms of biochemistry, focus on the practical. It may not be as helpful to memorize the Kelvin Benson cycle as it would be the metabolism of alcohol, since there will be a large portion of your patient population that will have alcohol problems. You should pay extra attention to your attendings on rotation. Watch how they perform, how they solve problems. Have your stethoscope handy at all times and be ready to listen. When you hear something funny, always ask your attending, 'Did you hear that too?'. That's how you learn. In summary, I would like my students to have a strong grasp of the practical knowledge. The bigger your knowledge base when you start, the more you can add through your clinical years.

For students reading this, the best advice I can give for when you begin to enter graduate medical training is to know your program and know yourself. Make sure the people you are signing up to work with are ones you can relate to and can respect. You are going to be with these people for a minimum of three years.

As a senior resident in PCOM's program, the attendings have high expectations for me. Though you spend a lot of time making schedules and arranging lecturers, you do become the right hand man for your attending. On Dr. Jeff Bado's service, he called me his "Number One", like on Star Trek. It was a great feeling to have that support from your attending. There were not many experiences that caught me off guard, since I am a person who does think consistently two steps ahead of the problem in front of me. However, there are some experiences which do catch me off guard – for instance, I can not pass up the opportunity to go to Haiti and help the victims of that mass tragedy. I feel like I absolutely have to go – that there is no choice but for me to go. As I approach the end of my residency training, I cannot emphasize how excited I am to become the 'guy'. Dr. Bado has an interesting theory about resident progression. He thinks there is a 10,000 hour mark in a resident's education– specifically 10,000 hours of patient care experience, when the resident becomes completely comfortable in seeing patients, managing patients, writing orders and wants to run the patient's care in the hospital. As an attending who teaches residents, you will notice this. The resident will begin to seek the attending's counsel less and less and will manage the patient singularly with little input from the attending. Dr. Bado is a pretty wise guy. It is a great feeling to know that you can manage a patient, no matter how sick they can be. I am really excited at the prospect of starting my career.

Now that I have considerable patient care experience under my belt, there are patients whom I know as I am getting their story that they are going to be a handful in the hospital. People who have given up on life and have turned to drugs, alcohol or both are the most difficult to manage. Throw in a couple psychological problems and that is a whole world of trouble. The patient that has given up on his or herself, who simply do not care, can be incredibly difficult to manage. I once had a 31-year-old woman who was admitted to the ICU with pneumonia from drinking and drugs. I remember thinking, "Good God woman, you are 31 years old with a family and children and you are doing this with your life?" You fix up the patient, let them back out into the world, they drink themselves to oblivion and they are back 2 weeks later – this can be a deleterious cycle for both you and the patient. At the other side of the spectrum, you have the 100-year-old woman who has been made a full code by her family. God bless the patient for making it to 100 years of age, but does the family really expect the patient to survive for many years longer? Families can at times be just as much if not more work than the actual patient.

Critical care patients get me going. I know that if I do not do the right things in the right order, in the next few minutes that patient will die. Critical care patients also require you to be Sherlock Holmes at times. When you have an incredibly long differential diagnosis and you have to work through the list, it can be a rewarding experience coming to an answer. We had a case of Babesiosis at Chestnut Hill. The patient had been digging for clams in Nantucket. He presented to the hospital with a cyclic crazy fever – 105, 102, 105, 100.4 – that was a difficult case! For patients that I had little idea of where to start, I would go home and read and read and read. That is the single best thing you can do for yourself as a medical student and resident during your training.

In residency and in medicine in general, you are exposed and placed into some pretty terrible experiences and tenuous positions in dealing with patients and their families. Ultimately, you make jokes to get yourself through the day. The best line that relates to this is from 'Scrubs'. JD, the main character goes, "We do not joke because we are heartless – I mean look at this – I have to go tell that family their father died. That family gets to sit there and grieve for the rest of the day; I have to go back to work. I don't make jokes because its fun, I do it so I can make it through the day." That is the best quote I have heard about being a doctor. You can get messed up in the head if you do not have the proper support structures. There are some terrible things I have to explain to families. We have to bite our tongues and do what is right or what the family requests. That is the definition of professionalism.

The Attending – Shaping the Osteopathic Physicians of Tomorrow – Pat Lannutti, DO

Written by Justin Guthier, OMS-III

The perception of humanism in medicine is changing dramatically. Traditionally, when physicians enter a room, they should sit down when talking to their patient. They should display small gestures like touching the shoulder or the arm and always turn around, to face the patient when leaving the room. My generation of physicians was taught to do this. Despite the lack of blockbuster antibiotics and medications, patients appreciated the thoughtfulness of their physician. Contrast that with what a patient said to me yesterday, "I am disappointed you are converting to computers. When my wife goes to her physician, they are all about the computers. They turn their back as they are talking to type on their computer." The generation today is the 'text not talk' generation. It is time to get back to humanism and I am glad to see an effort is being put forth.

I graduated from PCOM in 1971 and graduated from my residency in Internal Medicine in 1975. In 1967, PCOM had a dress code, and there were 100 students in a class. There were few women and few minority students. The professors ruled and taught by fear and intimidation. Students would get random and difficult pop quizzes so they would constantly be in fear of testing. To pass, it was necessary to read constantly. I remember one pop quiz in particular. John Simelaro, DO and I were classmates and were studying together the night of Dr. Martin Luther King's assassination. I wanted to watch TV to be up on the day's events, but John insisted that we read. Sure enough, the professor gave a pop quiz the next day in Anatomy. It was unrelenting. Anatomy is quite different today- we had anatomy all year long. There was no SPOM course – it was anatomy and you had to remember it all. Testing was done through blue books – I am not sure if today's students remember blue books, but they were little blue composition books with your name on them. Your grades were kept inside, so when you got them back you were always reminded of your past performance. The students were not permitted into the hospital before the third year, and if they were caught, they would be punished. The constant fear of examinations and intimidation of students lended itself to a terroristic approach to teaching medicine – much different from the environment surrounding today's students.

Although PCOM today is a larger institution, it is more family-oriented and supportive of its students. We have a vast array of basic science professors, but the biggest difference between PCOM today and the PCOM of my time is the immeasurable opportunities our students have for future career choices as compared to students during my time. Today, a PCOM graduate can attain an allopathic neurosurgery residency at a South Carolina university, take the neurosurgery boards and get the highest grade in the country. Our advancements in the osteopathic profession are comparable to traveling from Earth to Pandora in 'Avatar' – it is just a whole other world. Although we were confined to the osteopathic hospitals, the students in my class carved out fellowships in Pulmonary, GI, Nephrology and Cardiology. Dr. Kanoff, one of our current professors did everything in a little enclave and created a lot of opportunities for students today in Neurosurgery; now he has his residents all over the place. Pennsylvania and other hospitals have opened up – there is just more of the 'O' word for our students.

Older physicians will recall the old City Line Hospital. There was a hospital associated with the medical school at one time. I was speaking with a group of students and the topic of the old City Line Hospital came up and one student asked in all sincerity, "What hospital? – I did not know we ever had a hospital there." Students today cannot relate to the experiences I had at PCOM years ago. Is it better that we have all these hospitals that students have access to and not have the home base? I am not sure – I am of a bifurcated mind as to whether I want PCOM to have its own hospital or that it is better that we have to be so good as to make students want to come to our programs.

Currently, I am the GME director at Roxborough. Dr Venditto is the Internal-Medicine Director – I am the Vice Chair of Medicine. I have always enjoyed ed-

ucation. My job at Roxborough leaves me feeling fulfilled. The best part is dealing with the interns. Over my career, I have always sought students who are early in their education. If I taught high school I would teach the freshmen. It is fun to be around medical students in their freshman and sophomore years. You get into their minds and you can begin to mold them. The students in turn are unadulterated – they ask questions and have an enthusiasm that has been left behind by some upper year residents. Interns make a dramatic transition over the course of one year. Up until mid year, the interns can be molded. Mid year is when they begin to ossify. Then, they become residents and you cannot talk to them anymore. The most fun is helping make sure their education is one of quality and substance and that their lectures are stimulating and of high quality. As the overall supervisor, teaching keeps my mind fresh. My master role model is Dr. Saul Jeck, DO, Professor and Chair of OB/GYN here at PCOM. Although he is no spring chicken, he still maintains a heavy schedule; he is inspirational-this man has a fascinating mind.

I face new problems everyday and I enjoy the challenge of solving them. I subscribe deeply to the following quote from Louis Pasteur, "Chance favors the Prepared Mind". If you are not prepared for the opportunities when they present themselves, you will not be as successful as you could be. The part of me who is young likes the challenges, the other part of me likes things to stay calm; there is no way to get bored in this job.

I believe it is important to teach new physicians how to multitask during their residency training. There is a big problem with the hours mandated by the government. I learned to work tired – you all will learn to work tired. Philosophically, I have a problem with the federally limited work week for residency training. A physician trains for a profession, not a job where you clock in and out – it is the patient who determines our working hours. Fulfilling our responsibilities to our patients should determine the time we need to spend at the hospital. New physicians need to learn to 'pick it up' not quit at the quitting hour. The other obvious tenet I wish to instill in my residents is excellence – pushing the envelope. I must reinforce this idea – medical education is not training for a job where you can clock in and clock out; I hear the terms 'precall', 'postcall', 'pre-precall' and 'post-postcall'. I rarely hear the word 'patient' even though it is the patient that should be the focus of everything! One of our present residents, Ben Saks has taken this tenet to heart. He is completely focused on the patient, giving more than a little extra, a wonderful role model. We all need to strive for excellence in performance, variety in development, while not forgetting the human being at the other end of the stethoscope.

What makes a good resident? It is not a question with an obvious answer. Is it one who passes the board? Or is it one who can deal with a multiplicity of problems? Residents who are comfortable within themselves, who have confidence in their abilities, who do not feel the need to fire off huge differentials – these are qualities that make an exceptional physician. The boards are a concern to residents, and to many program directors – a hurdle. As long as there is a passing score, you will have a future. Some of our best residents do not have board scores in the 99th percentile. They are great doctors because of the personal qualities that drove them to careers in medicine. Those who keep the patient foremost will always be successful. We like to turn out general internists. The government's objective is to do this as well. We are encouraged when our residents wish to practice in areas that are underserved in the US. It says to me that our residents are 'people' people and I wish this for all our graduates. Our graduates can connect with their patients and create that humanistic relationship.

One of my favorite historical characters is General Eisenhower. He was not like General Patton- soldiers were scared to death of Patton. Eisenhower on the day before D-Day, walked among the troops. He said "You're from NY, I've been there – You're from New Jersey – never been there". He could command respect but still fraternize. I know I have been successful in my residents' education, when they can command the respect of their patients, their colleagues and their students, but still act in a humanistic way.

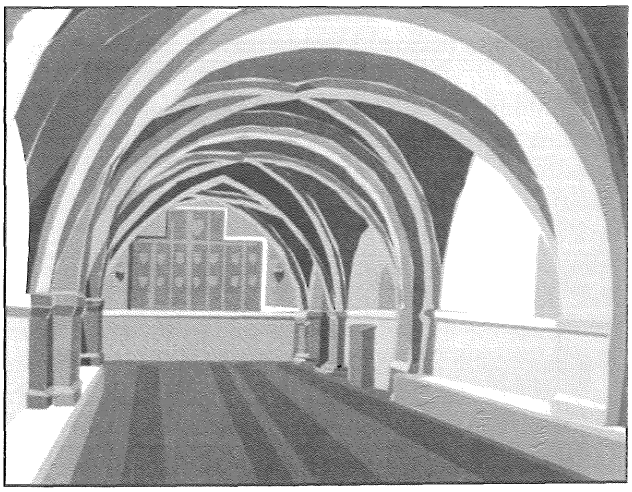
Medical students on rotation in comparison can find themselves particularly vulnerable; they do not know everyone, and everyone seems to know more than they do. When a medical student is asked a question they are only expected to know the basics-but they still need to have a thick skin as there are some who expect that you know even less than that. Internal medicine is a good rotation to have early in your training. I do not expect you to be able to do much at the beginning of the month, but at the end, you will be able to write a note, give a good differential diagnosis,

not obsess over an exam and be able to present a case. I cherish students who come to me and say, "I have no experience in Internal Medicine", and ask me to hammer away at them and make them the best junior they can be. I have had people come up to me at alumni dinners, and thank me for teaching them how to write their first note. You could describe me as tough but fair. I always ask a student if they do not know something, "For $40,000.00 why would you not want to look up that answer?" I will always say at the beginning of the rotation that no question is meant to embarrass. If they know your limitations, then a good attending will expand that student's fund of knowledge. One of the things I like to write in letters of recommendation for students is – "strives to expand knowledge" – this shows a residency director that you are striving to be your best.

Osteopathic GME continues to evolve into the future. It is ironic – students today strive to enter allopathic programs. Yet, the smartest thing those allopathic hospitals ever did was to let us in, because we can add another dimension to patient care. We need to decide what our relevance is as osteopathic physicians. When we have a woman with headaches up on the floor we should ask, " Did anyone do OMM on her?" We need to decide amongst the professionals in our osteopathic community, "What does it mean to be an osteopathic cardiologist? What does is mean to be an osteopathic nephrologist?" Only then will we be able to begin separating ourselves from our allopathic counterparts. The osteopathic profession needs charismatic spokespeople who can hold up themselves to the general medical community and promote our interests and advance the interests of all physicians. The government posts the Top 40 lobbyists in Congress every year. Professional baseball and the AMA are always on there. But where is osteopathy? I cannot emphasize enough our need for good representation nationally and locally in the medical community.

The osteopathic profession needs better PR. One kid made a video of himself walking around Rittenhouse Square and asking passersby what is PCOM? One bystander replied, "Is that a radio station?" Another asked, "Is that where you do not want to hurt animals?" When a prospective student comes for an interview, we ask them what does being an osteopathic physician mean to you. Of course the majority of applicants say that DO's have that human touch. And I will agree with that statement in its simplicity – we as osteopaths at PCOM have principles in our education that are different from Jefferson, Drexel or Penn. Our students definitely have more non-traditional applicants within the first year class. I think we turn out broader minded, more thoughtful people in terms of interpersonal relationships.

To all the students reading this publication, it helps if you know early what kind of practice you want to have - that way you can start planning for it. Students get worked up when you ask them what they want to be. It is not absolutely essential that you know on day one, but as time progresses, you can begin to choreograph your moves and make a name for yourself at your programs of interest. I had one student who came to me and said 'I cannot stand class'. He said he wanted to "get out of class and follow me around and be in the hospital". I was worried that I ruined his life. But let me tell you – he choreographed his moves, did his electives, aced his boards, got great letters and got into his program of choice at Dartmouth and was asked to stay. The best advice I can give students is to make up your mind within your comfort zone as early as possible and choreograph your moves. Talk to the residents in the program that interests you and let people know you are interested. People who know what they want can begin to get their life together earlier than their counterparts, simple as that. At some point you have to make a decision. Is it wrong to make a student think he or she has all the time in the world? Our catalogue makes you think everyone gets in somewhere and they do. But the catalogue cannot describe the maneuvering and all the hard work that went into that person getting into that hospital. So students – hammer away, stay late, be persistent and know what you want to do.



Putting Medicine in Perspective – Carl Luxardo, DO

Written by Justin Guthier, OMS-III

I still remember clearly the day that would forever change my life. It was finals week in my second year, close to Mother's Day, and I had just taken the dermatology final. I ran home after the final – I could barely concentrate. My wife was seven weeks pregnant and we were headed to get the first ultrasound. My wife and I convinced the obstetrician to allow us to see the baby's heart, basically so we could tell our friends and family that the fetus was viable. After a while he turned to me and said something I will never forget, "Do you know anything about ultrasounds?"

I came to PCOM from a small town in Northeastern Pennsylvania called Bloomsburg. The transition from a small town of 13,000 people to the big city of Philadelphia in my first year in medical school was surprisingly smooth. I was newly married to my high school sweetheart. We had gone to undergraduate school together and then ended up getting married a semester before we graduated. Having just graduated college, my wife and I were at a point in our lives where we were career-oriented. My wife's degree was in mass communication, which is a degree you can do a lot with depending on your creativity. Both of us were excited at our new prospects and big city life. I was excited about beginning my medical career and my wife had found a good job. Neither of us were going to miss Bloomsburg at all.

I always wanted to be a physician. Being from a small town, I felt that learning in the big city would allow me to reach my full potential and enable me to become the best physician I could be. My inspiration to go into medicine came from my mother who is a respiratory therapist and my family doctor. My family doctor had inspired me to enter medicine, particularly to become a family physician. As I was just beginning my first year, I knew it was important to keep my options open. I decided I would leave it up to my experiences and go with whatever turned me on.

Looking back, I have a lot of fond memories of my first two years. Being a medical student is very stressful, but my wife was very supportive. She enabled me to get my work done and allowed me the space to study and grow as a future physician. Immersed in her own career, she was also very independent. Her job had provided her with a lot of friends. We made the most of the time we had together. I cannot emphasize how important it is to value the people in your life. Most students realize that going through medical school you have to work hard. But you need to leave time to have fun as well – work hard and play hard! Little did my wife and I know that our lives were about to drastically change.

When my wife and I first found out that she was pregnant, it was a shock but at the same time exciting! Even though it was a surprise, we both knew that we wanted to have children and we both thought that one child was manageable. My wife would continue to work and our finances would be adequate. The two of us could not wait to see our baby for the first time on that ultrasound.

I still remember clearly the day that would forever change my life. It was finals week in my second year, close to Mother's Day and I had just taken the dermatology final. I ran home after the final – I could barely concentrate. My wife was seven weeks pregnant and we were headed to get the first ultrasound. My wife and I convinced the obstetrician to allow us to see the baby's heart, basically so we could tell our friends and family that the fetus was viable. After a while he turned to me and said something I will never forget, "Do you know anything about ultrasounds?"

I said, "No, I have not had a clinical radiology class yet, I just know the basics."

The obstetrician frankly stated, "Well…there are three sacs here". At that point, I thought maybe he was quizzing me and my mind raced – 'that does not seem right'. I pointed out structures on the ultrasound to impress the physician. The obstetrician stopped me mid sentence and said, "NO, no, no – you do not understand, there are three babies here".

At that point my wife turned to me and I looked at her because we had discussed the possibility of twins. Her Grandmother had had twins. It was overwhelming, we both were in shock. We never expected to be having triplets. I looked down at my feet in disbelief and was completely quiet and stoic. All of a sudden I heard giggling and looked up to my wife, giddy and happy at the news. The physician looked at me and reassuringly said, "Just relax – although there are three potential babies, I have not seen the hearts … yet". He moved the ultrasound probe a couple of inches and we could all see three beating hearts. With an affirming tone, the obstetrician stated, "Well, you have three kids – triplets". The first thing I thought was, "That's it?". My wife was just laughing out loud, filled with excitement. However, I was having the most overwhelming feelings of my life, "How am I going to support three kids on a medical school budget? What are we going to do?"

The doctor knew my condition and said it was too

early to tell if all three fetuses would make it to term. He said to come back in another three weeks for a second ultrasound. We made appointments to see an obstetrician to find out if my wife could carry all three babies to term. We talked about selective abortion in the event that there were three fetuses. There were a lot of factors to consider – could my wife physically handle carrying three children at once? Would selective reduction increase the chances of survival? This personal decision was one my wife and I could not bear to make. Neither of us could accept this option. For whatever reason we were meant to have these kids and we were determined to see it through.

When I arrived home from the obstetrician, I was visibly stressed to say the least. My wife was considerably more composed than I was. In light of the amazing news, we could not wait to tell our families. My father was in total disbelief that this could happen. I told him that the doctor said some people win the lottery – but you won triplets!

The end of second year was a real challenge for me. I still had the most difficult exams of my life to complete. The exams were tough but I passed. The month given to us to study for boards was incredibly stressful. God willing, I passed the boards and felt proud of my score, considering the stress of thinking about my future "brood". My wife and I were excited about the future. We were constantly talking about what our living situation would become – where we would live, how we would live, how drastically our lives were about to change. It was an overwhelming but exciting time in our lives. Many people throughout the PCOM community and in my personal life were incredibly supportive. The financial aid officer reassured me that I could make it through and I knew that my wife would continue to work as long as she could. This was simply a period where my wife and I began to adjust to the idea of having three babies. Once I was adjusted to the idea, life continued and I eagerly awaited the gift God had given us.

Everything was going well up until my wife's twenty-second week of pregnancy. We went for a routine ultrasound on August 23rd. My wife was getting very big and planned to stop working at the end of August. Upon examination, the doctor found that my wife was a centimeter dilated. At that moment, I did not realize how bad she actually was. The doctor called for a gurney to be brought to the exam room. He looked at my wife and said with complete concerned brevity, "You are not to set a foot on the floor again until you deliver". My heart sank. The stories and conditions you read about in text books was happening to my wife and to me. My wife is not a very big woman and even a 2nd year medical student could see it would be difficult for her to carry three children. I was no longer in control. My wife's health and the future of my family controlled my life and weighed heavily upon my thoughts.

The day my wife was admitted to the hospital began a difficult time in my life. The doctors had ordered her on strict bed rest. Different physicians presented us with conflicting opinions. The decision lay between placing a stitch in the cervix to prevent her from further dilating or to simply place her on bed rest. The worst moment during that first hospital stay was when the neonatologist came to our room and spoke to us about survival. He told us that survival of a twenty four week neonate is poor, let alone triplets. It was really a scary point because we had no idea of what was going to happen. The dreams we had had weeks ago seemed to be slipping away.

Getting to thirty two weeks was our goal. There was a 98% chance that the babies could survive and lead healthy lives if they made it to thirty two weeks. During this time, my wife had to remain in bed rest in trendelenberg position. She was on so many different drugs to keep her uterus from contracting. Magnesium sulfate was probably the one with the worst side effects. It is a drug that makes your whole body vasodilate. Since my wife was laying with her head down, the blood would constantly run to her head and her upper extremities. Not only was it difficult for my wife, it was twice as hard for me to watch. Her face and upper torso and extremities were flushed. My wife sacrificed a lot. Her time on bedrest at the hospital was the most difficult period in our lives. We were so scared. When we were newly married, I would not have dreamed that we would be spending the beginning of our marriage dealing with such a difficult situation.

We decided to be as aggressive as possible and agreed to have the physicians perform a cervical cerclage – a rare obstetrical procedure where you sew the cervix closed with suture. My wife and I were determined that she reach 32 weeks. Despite our determination, the physicians prepared us for the possibilities. There was an 80% chance that she would make it to thirty two weeks but also a 20% chance that her membranes would rupture and she would have to deliver in 48 hours time. The medical staff provided me with a beeper in order that I could be contacted at a moment's notice. I hated that beeper, because whenever it went off, it was never good. For that period of time, where my wife was in the hospital, nothing mattered except her. All of my anxieties about how to pay for a house, the children – did not seem to matter much at that point. I prayed that everything would turn out alright. My friends and family gave me lots of encouragement. They could clearly see my wife and I were in a difficult period in our lives. The future of our family

lay in God's Hands.

For sixteen days, my wife laid still and amazingly, she did not have any contractions. We crossed out every day until the doctors said it was safe to get up and take a shower. With strict instructions to rest and home monitoring equipment, we were discharged from the hospital. We made arrangements for both our Mothers to be home to take care of my wife since she could not get out of bed to make meals or do anything for that matter. The mere fact she was home was a great relief to my wife. Mentally, for my wife it was quite therapeutic to be out of the hospital. She equated herself to being a human incubator. As an intelligent woman, bedrest was not an easy task for my wife. She missed her independent and active professional life. Being in the hospital was so difficult. Though it was nice she was home, in all honesty, I had more confidence with my wife's care when she was in the hospital, knowing she would be on strict bedrest. The big weeks went by slowly. I constantly checked and rechecked my beeper when I was out for the day on rotation to be prepared for any news. The big weeks went by – 28, 30, 31 – and all of a sudden – BAM – we were at 32 weeks.

When 32 weeks came it was a Wednesday, October 31st - Halloween. I remember everything distinctly. That Friday when we woke up, we thought her membranes had ruptured. We rushed to the hospital and the doctors gave my wife tocolytic medications. Though 32 weeks was considered "safe", the physicians wanted my wife to go as far as possible. They gave her the medications and checked two hours later. To their and our surprise, my wife was 7 cm dilated. There was no turning back at that point. The physician asked us, "Do you want to go for it?" – could my wife have a vaginal delivery? All of the babies' heads were oriented in the proper position. My wife with confidence stated - "Yes". Later my wife remarked that the epidural was the most painful part of the delivery. We had planned for a C-section but this unexpected good fortune allowed her to have a vaginal delivery. It was tough for my wife especially since she did not have Lamaze training. In the delivery, there were a lot of people in the room: three residents, the attending, medical students, the neonatologist, neonatology staff, obstetrical nurses, but above all my wife was the star! She did excellently. When all was done – I was the proud father of three girls! The neonatology staff quickly whisked the babies away to the NICU to keep safe watch on our three little treasures. Thank God for steroids because when the babies were born, they did not have to go on ventilators. It was just a miracle and I will never forget it. When the babies were born so many people congratulated me and said "Now the hard part begins". I thought to myself, "What could be harder than this?"

Over the first three weeks in the NICU, the girls progressed slowly. Then one of them ended up getting sick in the NICU. I got a phone call one morning saying that one of my daughters had bloody diarrhea and possible necrotizing enterocolitis – a serious complication for preterm infants. Luckily, it did not progress to a surgical emergency, but it set my daughter's discharge from the hospital back a whole week. There was nothing more frightening for a young father than having to see his children seriously ill. All of our children made it through the NICU and were discharged home shortly after Thanksgiving that year.

First time parents – with triplets to boot – and a medical education still to complete, I still to this day do not know how my wife and I pulled it off. It was a tremendous and overwhelming responsibility. We had to get the girls up from rest every two hours to feed them so that they could maintain their growth and not become hypoglycemic from sleeping too long. My wife and I decided that if we stagger this duty, then there would always be someone up, whereas if we got them all up at the same time, we would have some time to sleep. Sleep was something that neither of us was getting in very large quantities. It was difficult, but the excitement of new children helped pull our spirits up and get us through those first few weeks.

A couple of weeks after the girls came home, I had a pulmonology rotation with Dr. Venditto that I will never forget. My rotation was scheduled to begin at 7AM each day. I would get out between 2 and 4PM, since I was allowed to leave early. When I got home I would get three hours of sleep and help with the children. Then at 10PM, I would wake the girls all at once. I had to be back and ready to work at my rotation no later than 7AM the next day. It was a grueling schedule. When I saw my wife, she was exhausted from taking care of the children. Together, my wife and I made the decision to move home to be closer to our families for support. In addition to working, learning medicine and taking care of children, my wife and I had to pack our things to move back home. The stress of it all began to really pile up on me.

During the first three months of the girl's lives, my wife and I were totally exhausted by the effort to make sure that the babies were all fed and pooped. A few days before we were scheduled to move home, one of the girls began to have digestive problems. She began to vomit immediately after eating. I gave her 1 ml of Pedia-Lyte at a time, and around the 6th or 7th ml she would vomit. The pediatrician was convinced the baby had gastroenteritis and said to keep feeding her through it. I had had enough at that point and took her to the emergency room. Hours later, the doctor diagnosed her with pyloric stenosis.

The day we were going to move, our daughter was

scheduled for surgery. We postponed everything until the following weekend and after several days our daughter came home and began to thrive again. When we finally did move it was more difficult since the help we had arranged could not assist in the move as planned. I had to do most of the moving myself while my wife tended to the babies. I was slowly becoming overwhelmed. While all this was happening, on rotation, I began to get many of the questions I was being asked incorrect. Lots of questions I should have known the answer to I had no idea. Whenever I sat down to read, I would fall asleep. At afternoon lectures I would fall asleep. It was exhausting. After the move that December, I arranged for housing at the PCOM Fraternity House. I thought that my move back to Philadelphia to focus on school would be good for my wife, our marriage and our children. Unfortunately, focusing on school was a lot harder than I thought it would be.

The overwhelming responsibility and physical exhaustion of my schedule over three month's time began to weigh on me. The excitement and happiness that new babies brought to my wife and I had worn off. Now we had to figure out how to make "this" all work. When I was in Philadelphia on rotation, all I could think about was my wife and the children. My wife needed my help and I could not be there. When I did come home, I did as much as I could. The girls demanded so much of our attention and when I came home my wife needed a break. On the weekends, she would have to get out of the house or just sleep, while I took care of the children.

This phase was more mentally stressful than physically stressful. I had all of this responsibility and I was not living up to it. The life of happiness with three babies between my wife and I was not developing the way I envisioned. When I was not sleeping, I was just worn out. When it was time to sleep, I could not relax and it was difficult to fall asleep. I did not feel like eating, I could not concentrate. When I would call home at night during the week, all I could hear was the children crying in the background. I knew that my daughters needed me. One night my wife and I hit the breaking point. Together we decided I had to take a leave of absence. My medical training was an investment in myself and a life for my family. Yet, three small babies were just too much for one person to handle.

As the months past, I spent all of my time at home with my wife. With the help of our families, we began to take control of our responsibilities. The biggest piece of advice I can give to whoever reads this is if you want to be successful you need to get into a routine. It does not matter if you have three babies or just yourself – a routine affords you a level of control over your life. For the first year of my children's lives, I felt as if my life was out of my control- which in the simplest terms it was. I did not realize it then, but when you have children, your life is not your own anymore. For many first time parents, that is the biggest transition in raising children. For my wife and I, that experience of losing your independence and gaining newfound responsibility to another person was tripled. With our routine established, we have become an efficient parenting team.

Now our triplets are 12 years old. We raise the girls as normally as possible. Though my wife and I became known as the "Mom and Dad of triplets", we raised our daughters as if they were three sisters of no particular age or relation. The girls are all black belts in karate, honors students and are all standout soccer and softball players. My wife and I also had a 4th daughter who is now six years old. We feel so blessed to have such a wonderful family.

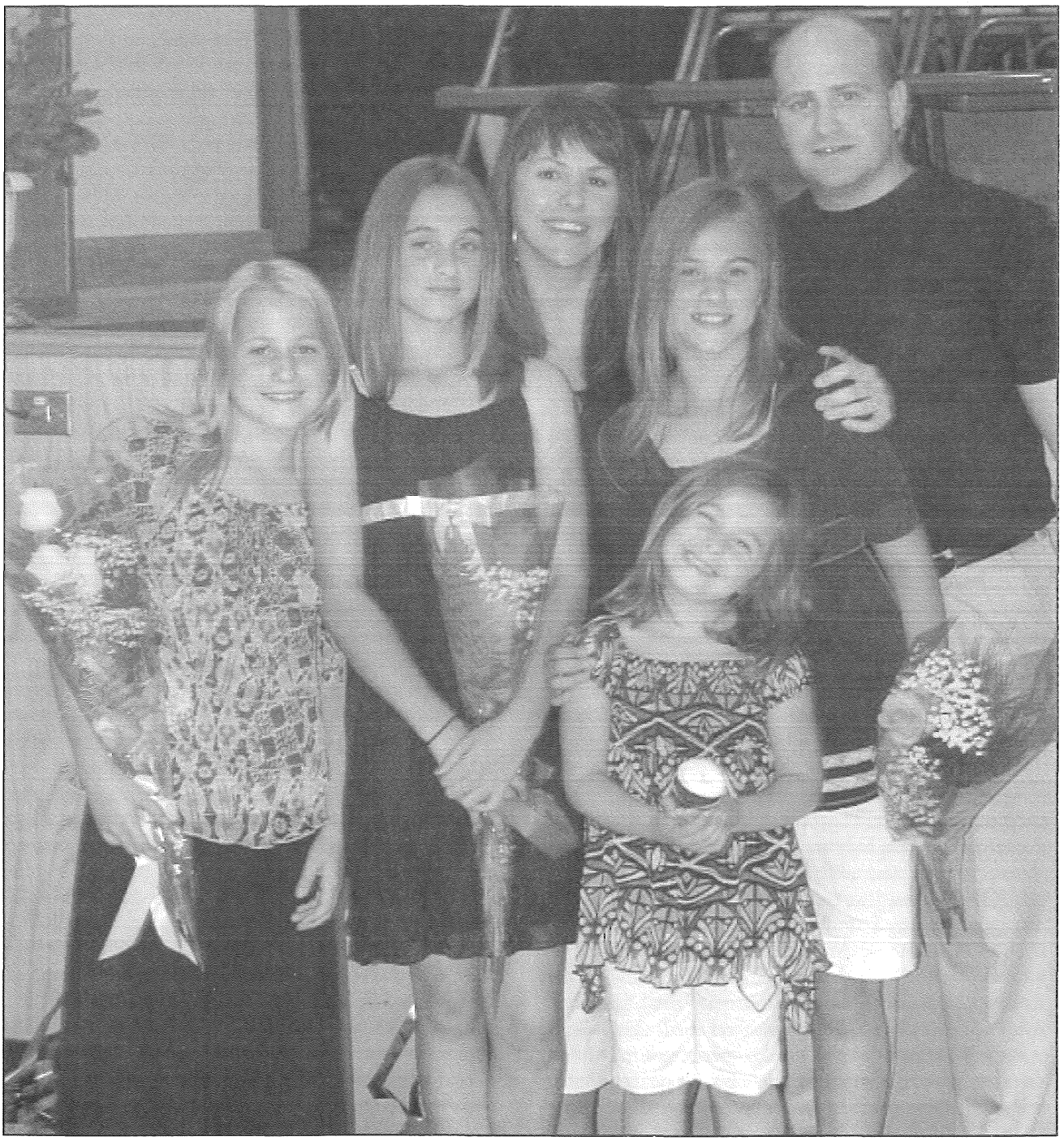
Despite all of the increased stress towards the end of my medical education, when I graduated medical school, I was 12th in my class. I was accepted to the Geisinger Family Medicine Residency Program. After completing residency, I stayed on at Geisinger and now have two family medicine offices in Bloomsburg, PA. I am deeply involved in my community. I coach my daughters' softball team and am the team physician at a local high school.

In terms of my medical education, I have a new appreciation for having the time available to read and review what you went over that day on rotation. My first two years of medical school, I was able to have the "typical" med student experience. I studied constantly and I did well. After my life changed from having children, personal time to read constructively, became a valued commodity. When you are asked questions on rotation, sometimes you feel like your teachers are trying to embarrass you. But I realized during this stressful time in my life, that answering those questions is more important than just trying to impress your attending. Your patients are depending on you to answer those questions-this is the sole purpose of our training, not to look good in front of your peers, but to learn how to treat your patients properly.

So many of us in medical school are visionaries; in order that we may become successful, we need to plan ahead – more often times than not months even years ahead. If you had asked me when I started medical school if I would be the father of three girls during my third year, I would have laughed out loud. You never know what life is going to throw you. When I was taking care of my children during that first year as a parent, I was in medical school mode – thinking ahead, years ahead, trying to hatch out a plan. Now I have learned that if you look too far ahead, you can be-

come overwhelmed. Take a breath, do your best, adapt to challenges as they come. When I am home, I try to be as good a father as I can and when I am at work, I do the best I can in the hospital.

Everyone says that life experiences make you stronger – this is undoubtedly true in my case. People can go through life without many bad times and in some cases find it hard to appreciate the good times. Becoming a parent has definitely helped me professionally. A physician has to be able to relate to people. I think this is imperative to being an effective healer. You must understand where people are coming from. When patients come in feeling that their world is out of control, I can sit back and say "you know, I remember when I was in a similar situation". Everyone's experiences are different but when it comes down to it we all have feelings we can enlighten and share with one another. When patients come in and describe the hard times in their life, do not blow them off. Listen to them, respond, be a physician.



PHILADELPHIA · COLLEGE · OF · OSTEOPATHIC · MEDICINE
4170 CITY AVENUE · PHILADELPHIA · PENNSYLVANIA 19131-1694 · www.pcom.edu
OFFICE OF STUDENT AFFAIRS · SUITE 101 · EVANS HALL · 215-871-6780